

Experiences and thoughts on training in psycho-oncology

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Abstract

Those who wish to concern themselves with training in the psycho-somatic field and, in particular, in the psycho-oncological field need to face the constant work of working through the passage from defensive splitting to operational splitting.

A psychoanalytically trained observer, who comes into contact with an institution, as G.Vetrone says (1986), is quite soon aware of the fact that inappropriate splitting operates within it, for he discovers with amazement, anxiety and disdain, that some human needs are denied and the patient is related to as if he were a part-object. Recognising the splitting is a sterile operation if one does not understand the specific anxiety which made such a defence necessary. The observer must be able to identify not only with the more evident suffering, that of the patient, but also with that of the carers, which is generally more difficult to recognise precisely because, through splitting it disappears or becomes projected elsewhere. Apart from this process there is only space for moralistic judgement.

Key words: psycho-somatic medicine, psycho-oncology, psychoanalytical observer, institution, formation of operators staff

The field of psycho-oncology includes experiences, thoughts and attempts at theorizing in a psychosomatic frontier area with all the ambiguity of the difficult relationship between biology and psychology, medicine and psychotherapy. That hyphen which, as Winnicott (1966) says, links and separates.

We have asked ourselves why that which is taken for granted in oncology is much-discussed or ignored in other confrontation areas between medicine and psychology. In fact cancer seems to have gone beyond doubts and differences: it is a widespread opinion that the psychological implications must, in some way, be taken into consideration.

One first consideration concerns the fantasy which sets the equation tumour = death. This fantasy is deeply rooted in a peculiar way compared to other serious and potentially fatal diseases. The indeterminate aspect of the causes and the self-generating aspect of the disease - defined as a malignant, indefinite and anarchic growth of crazed cells of the same organism - conjures up the disquieting fantasy of a part of the self which is transforming into something other than the self. This something is destructive or lethal and causes distressing confusion between victim and persecutor. The activation of very primitive and persecutory fantasies involves the relationship patient-family-carer-environment. It obliges one either to take up only the concrete aspects of the disease or idealise the aspects of suffering and

martyrdom which places the cancer patient in a separate, different dimension. The search for interpretative models with a linear psycho-somatic relation may even represent the defensive attempt to circumscribe psychological categories and constellations: the causes of cancer may then be ascribed totally to them.

This brings us to another consideration. The increased awareness of the psycho-social problems of cancer patients may reflect even the condition of isolation and the urge for reparation that such patients evoke. Cancer treatment is experienced as a challenge on the biological and cultural dividing line of death. The treatments and the technological innovations are as yet more or less experimental; they create risks and suffering and, in spite of successful outcomes in many tumours, they do not automatically guarantee a cure. Patients, families, carers have all to live with the uncertainty and the spectre/phantom of urgency for years, in the most favourable cases, oscillating between depression and manic denial (De Luca, 1997).

With such assumptions, the increased occurrence of tumours and the failure to solve the tumour mystery have activated requests for intervention, for support and for psychological training. All of this may reflect also the need that carers and environment have of being able to better face the identification anxieties in the relationship.

Group experience in post-graduate university education

Despite a multiplicity of experiences of great interest, up to now there is not, in the field of the global assistance offered to a cancer patient, an institutionally defined and acknowledged cultural and educational training programme which would enable a confrontation on the aims, methods and limits of psychological intervention in oncology.

My experience as a teacher in a post-graduate course on Oncological Psychology at the University of Rome, La Sapienza, represents one of the stages of an evolving personal and cultural process continuously in confrontation with other Roman and international experiences.

The course lasts one semester and offers a first level of awareness to the medical-psychological problems linked with the treatment of cancer patients. It is open to doctors and psychologists and can be said to be within the framework of clinical psychology. Obviously the course does not qualify for the practice of the psychotherapeutic profession. Generally the medical and psychological aspects are dealt with separately by oncologists and psychologists, the latter prevalently with psychodynamic training.

Due to my own professional development, from haematologist to medical psychologist in charge of a Psychosomatic Health Service for cancer patients, I have been assigned the task of integrating medical aspects and psychological aspects. I hold lessons on the psychological implications of haematological diseases and a work discussion group starting from clinical situations and case material.

The groups varied from 6 to 12 participants with a total of 16 weekly meetings, lasting one hour and a half, held in the Oncological Psychology Unit.

Participants were prevalently psychologists or doctors who were completing a psychiatric-psychotherapeutic specialisation. With the exception of one group, none of the doctors were oncologists. We do not have sufficient elements to explain this fact, which should be compared with the other courses on psycho-oncology. We could assume that working oncologists may be more fearful of upsetting their professional framework with the risk of losing the certainty of fixed references in their daily work. Secondly it could be difficult for the only, so to speak, expert professional to have to confront doctors and psychologists at a first level training course.

The work discussion group had the objective of providing an opportunity to experiment the fantasies and the experiences activated by cancer. Another objective was to highlight the necessity and feasibility of integrating the technical aspects of treatment with the psychological need to make sense of the experience. The approach was a psychodynamic one. Apart from it being a prevalent part of the group leader's training, the psychoanalytical model is the one that most acts on the psychological mechanisms in a phase of regression and on the symbolical working through of the experience. In our opinion this is indispensable in order to understand communications from patients who, because of the seriousness and peculiarity of cancer, are inevitably exposed to phases of even very deep somato-psychological regression. These patients evoke counter-transferral reactions in the carers which are often very primitive and difficult to perceive and work through without the adequate training. Such understanding seems to us the indispensable basis in order to think of an experience such as cancer which, with its crushing concreteness and the experience of alarm it evokes, fosters massive splitting and denial - hardly economical from the biological and psychological point of view.

Peculiarity

The type of work carried out in the group cannot be traced back to univocal experiences and this entailed continuous redefinitions and adjustments. At present these groups have been suspended in order to reflect on their validity and possible modifications.

The participants expectations were often that of experiencing a Balint-type group (Balint, 1957). In actual fact, even though the Balint experience is fundamental to those who wish to work on psychological mechanisms in the relationship with somatic patients (Comazzi, 1995; Carbone, 1995), this type of group is somewhat divergent from a Balint-type experience in many aspects.

First of all the group was not an optional part of the course; it was not formed on the basis of voluntary participation nor did it contemplate any screening. This, according to me, proved a limitation with regards to being able to face in greater depth certain issues which came to the fore without running the risk of changing the group into some sort of clandestine therapy.

Secondly it included the presence of medical professionals and psychologists with the objective, throughout the course, of working on the confrontation between roles. This

enabled us to bring into focus some of the issues typical of multi-professional teams. This, according to us, was one of the most fruitful aspects.

Thirdly one of the recurring themes was that of work on the biological aspects of the various oncological pathologies, on their peculiarities and on their correlated specific fantasies. This aspect reflects my own training in both the medical and psychological field and, above all, a personal experience as regards what should be the professional background necessary to anyone who intends to help patients with a somatic disease under way. A professional who resolves to work on the psycho-somatic dividing line must not lose sight of either of the two needs. Research on confrontation and testing with other work groups is in progress on the basis of these assumptions.

Finally, defining the length of the group, in a relatively short period of time, needed great attention in order not to interpret areas which could not be worked through in that amount of time. However, it did provide the chance to work on the anxiety related to separation and loss, which are present in the experience of cancer.

Suggestions from the group

A problem of identity. At the beginning of the group the participants talk about personal experiences with members of the family or friends and acquaintances suffering from cancer and the need to learn what can be done in order to give the help they did not receive. Confusion is created between the sick and the healthy, between learning and working through bereavement. It appears that it is possible to face contact with cancer only by distancing and intellectualising.

Tumour equals terminal disease. The first clinical case was that of a terminally-ill patient who was, according to the person reporting, unaware of the seriousness. It was a patient with an infiltrating and devastating cancer starting from the oral cavity; he was bandaged and unable to speak. The patient does not know and does not communicate. The group calls him the invisible man.

Anxiety brings into work the inability to think and operate. During discussion the group seems unable to let emotions and fantasies circulate. A type of medical defence is enacted and detailed case history descriptions are requested by the participants. Solitude and the psychologist's feeling of helplessness rules. The psychologist becomes isolated from the medical group and is looked upon with distrust as the person who will reveal the reality of death. Can the psychologist take on this patient; can the group take responsibility for its object?

Regression into dependence. The only way to face the situation seems that of delegating to a strong and caring person who can create a gratifying and illusory reality.

In subsequent meetings what emerges is that the invisible patient had been a heavy smoker and drinker, unable to set the family any rules, but active in his work. His wife seemed to have taken upon herself the role of setting rules and now she is her husband's spokesman. Cancer seems to give concrete form to the needs for dependency. It enables regression into an exclusive couple relationship which, however, cannot have any transactions on the level of reality as the patient must not

know. The group fantasises about cancer as punishment and extreme oral eroticization; it allows deep regression, but only on condition of losing one's voice, losing any say in the matter, losing the ability to make requests. The group suggests not attacking the dependence but supporting the wife's caring role so that she may better understand her husband's feelings.

As soon as we approach fantasies, thoughts and feelings a psychologist suddenly asks the group not to build castles in the air, to stay with their feet on the ground and stick to the facts: the psychologist takes upon herself a part of the medical aspect, as a defence against thinking, against being contaminated by the fantasies.

The lethal risk of growing. We broach the problem of differentiation and individuation with the case of Mr and Mrs Y undergoing couple therapy. The therapy was requested by Mrs Y who started with a successfully treated lymphoma and subsequently had two other tumours with uncertain prognosis. She experiences the three situations as one disease and suspects that they are caused by something wrong in her life. She is angry and disappointed with her married life. She gets her husband's exclusive attention only when she is ill and she feels the time has come for her to free herself of the disease. Her history indicates that the onset of the lymphoma occurred when, at a very young age, she married because she was expecting a child, which was however wanted by the couple. The disease obliges Mrs Y to rely on the help of her parents and her son is practically brought up by the grandmother. The son, described by the therapist as very handsome and intelligent, withdrew from family counselling in order to permit couple therapy. We reflect on the nature of the lymphoma - a tumour of lymph node tissue - normally involved in the defence and the acquisition of identity. The tumour seems to represent the inability to differentiate and separate. It comes with a transgressive pregnancy and marriage. Mrs Y seems to give up her maternal role, handing her son over to her own mother. The son, who is described in very idealised terms, seems to have to keep himself away and uncontaminated.

It seems difficult for the group to grow and differentiate itself, to put forward generative projects and fantasies without running serious risks. The couple seems to be founded on a regressive mechanism linked to the repetition of a deadly threat. The subsequent tumours trigger off fantasies of the phases of a perverse degenerative development. The group formulates the distressing hypothesis that the idealised aspect of their son is in reality a schizophrenic trait.

The theme of contagion. This case seems to deteriorate the possibility of maintaining a clear distinction between physical and psychological disease; contagion related anxiety is activated to the point of breaking down the ability to think.

In parallel also the husband is undergoing treatment and the news that he is coming up against obscure and disquieting physical problems, which even cause hospitalisation, activates the fear that staying in touch with emotions linked with cancer actually brings on the disease. The carer catches the disease. The case closes with more recent news that brings relief and euphoria to the group: after the

interruption related to the husband's illness, which was resolved, the therapy of the couple was resumed and changes are taking place.

Crisis and change. The last case takes up the last meetings of the group and represents its conclusion. The case of a young woman with cancer at an advanced stage was brought to the attention of a psychologist by the patient's sister who is taking care of the patient. She is the only member of the family who has not got cancer and the only one who chose to work and lead a different lifestyle from the rest of the family. However she imposes a silence in relation to the real extent of the seriousness of the disease; not only with the patient herself but also the parents and close friends. The family seems artificial, respectable, very concerned with its image. No-one knows the whole truth about the disease.

Behind the facade of conventional, idealised relationships there is a devastating inside: the cancer, giving concrete form to powerful and anarchic fantasies. The only witness who takes upon herself the responsibility of the truth stops it from circulating. The psychologist is stuck between the urge to help the patient and the charge not to break the illusion.

The group, which identifies with a family contaminated by cancer, seems to ask itself if it is possible to face the imagined and the real aspects of the cancer disease without resorting to splitting and idealisation.

After an initial contact the patient is hospitalised in another city and news of her become vague and inaccurate. The group fantasises that there is nothing more to be done - only palliative medications - and experiences the anxiety that there is no longer any time in which to formulate a programme for psychological help. The feeling of helplessness is overwhelming. We are about to end the course and the group complains it has not received definite behaviour rules useful in relating and communicating with cancer patients. Is it in any case possible to enter into a relationship with an object that is so precarious and at risk? I point out that we are about to separate and that the object of our meetings brings up a deep anxiety related to loss. Perhaps they want to draw attention to the fact that not only there is insufficient time, but that there is not even the possibility to take away something good from our meetings. We have been in contact with many painful feelings but we are not ready for loss.

In the subsequent meeting the psychologist informs us that the terminal patient is no longer terminal. She is to undergo further treatment. She contacted the doctors and faced clearing up the uncertain boundaries of the prognosis and the medication programme which at the beginning seemed immaterial. It is not known how it will end but there are margins for improvement: the patient continues to respond to the treatments.

The psychologist has met her, she appears lively and active and is planning a holiday. The psychologist perceives her as uncertain concerning their work together, perhaps she feels the help was requested to help her to die, while she wants to be helped to live.

We will use the psychologist's words as a conclusion to the group: he reports that he is in a state of confusion and change. He trained in a type of directive psychotherapy which he had thought of placing at the service of terminal patients on their journey towards death.

He came to face not cancer and death but life situations which were very different and unpredictable on a physical and psychological level. He feels bewildered, his thought patterns have been upset. He feels like an explorer in a new field, he needs to understand the road he has travelled on and to determine how to continue. What he felt to be therapeutic passivity he now feels to be what he must do: listen. He does not feel the need to get out of the impasse, he no longer wants to take refuge in rationalisation and organisation according to a rigid grid reference of life-death and diagnosis-prognosis. He feels he wants to know what it is about and what each single patient needs, and as a therapist to offer more honestly. We say goodbye to each other giving up the idea of asking ourselves: how much is there to live? or when will death come?. The problem is to understand and share the somatic event and discover with the patient what meaning there is to this experience in order to accept the losses and find the means to travel that part of life's journey which is given to us.

Recurrent themes

What frequently emerged in the various groups was the experience that cancer patients are the equivalent of terminal patients and this identification could be linked to the fact that still today the help of a psychologist is often requested only when the chances of survival diminish. What emerged during the discussions was that the group confusedly perceived in the background that as long as there was the chance of medical treatment there was no need for psychological treatment. Much of the work served to pinpoint how working through the experience during the early stages of the disease helps to travel a painful and uncertain journey, even in favourable cases. Not doing so signified giving up a very powerful tool for strengthening the areas concerning the motivation to live and the possible adaptive changes which can increase the chances of successful treatment and allow the patient to make choices with as much awareness as possible. In fact early and correct psychological intervention not only affects the quality of life but also the development of the disease. Such work acquires, in the long run, even a prophylactic value for psychopathological consequences which constitute one of the most costly outcomes of the experience of cancer patients and their families. Some doctors expressed the fear that the psychotherapist could take energy away from the patient and depress him by dealing with the negative feelings as well instead of concealing them. In this sense concern and mistrust frequently emerged especially towards the psychoanalytical approach. As one member of the group said these divers of the unconscious see guilt everywhere. This enabled us to highlight a persecutory aspect connected with cancer. The group signalled the anxiety of discovering a relationship between guilt and disease. Faced with the inability to explain the causes and the powerful homicidal vitality of cancer (Fornari, 1985; Chiozza, 1978) patients often ask but what have I

done to deserve this? Many find their own answers, they identify their own nemesis and with greater or lesser awareness feel it is pointless to fight against fate. Being able to work on this is very important in order to reduce the feeling of the inevitability of the patient's fate of death and expiation, which cancer prompts. If the combination guilt-expiation is not worked through cancer takes on the value of a symbolical equivalence which does not allow to make sense out of it and inhibits choices and behaviour tending towards life.

A clinical case: the mother of a young patient has a violent emotional break down when her daughter is seriously risking her life. She loses control of the secret which she had never shared with anyone: the story of her own family of origin made up of violence, perversion and delinquency. She had sworn to bring up an ideal family without stain and in keeping with the rules. The patient, the first child, is dedicated to God to redeem the maternal family. But her attempt to expiate fails; punishment has now arrived. A. has never done anything that could cause her parents pain; she is brave, lively, optimistic, a real model for the whole ward. She cries only with me. With difficulty she reveals fear and rage. She refuses to show these feelings to her mother, she is certain they would damage her. In this game A. does not reveal the premonitory symptoms of the complications which risked causing her death in order not to worry her mother.

Another constant was the impossibility to communicate on cancer. Frequently the group members debated whether to tell or not to tell the truth about the diagnosis and the prognosis transversally dividing into mixed groups of both doctors and psychologists. Diagnosis and prognosis was an interesting aspect: statistical probability was invariably identified with the certainty of that single patient's fate. The emotional need was to have some certainty before them, even if negative, to be able to bear the persecutory anxiety linked with the fantasy of an invisible enemy ready to launch an attack at any moment. In any case the group members seemed to forget that according to the law and for a proper management of the treatment it is not a discretionary issue whether to communicate the diagnosis and prognosis or not. The phantom that circulated constantly was that to talk freely of cancer meant to inject death (De Luca, 1999). As regards this aspect it was extremely clear how in fact technical and emotional communication become muddled when dealing with cancer thus blurring ethical factors and professional necessities. It is in this sense that the psychologists, unaware of the technical aspects and the objectives of the treatment which primarily bind the doctor and the patient, were unable to perceive the risks of a non realistic communication. Their comments often carried the idea that the motivations for a clear communication of the diagnosis were exclusively connected to ethical considerations. The idea was that the technical apparatus of the treatment was something objective and automatic and that it could not be influenced by the modalities with which the patient understood and applied the treatment.

As De Benedetti Gaddini (1992) says, how can a doctor discuss his patient's death anxieties if he perhaps studied medicine precisely because he wished to control his own anxieties and did not dare to meet them? To this let us add, how can the

psychologist begin to approach the feeling of a reality based deadly risk, if he chooses the symbolical way in order to exorcise death and never meet it?

Psychosomatic training and role problems

The psychological implications of somatic diseases may be studied in terms of the psychological causes of diseases, in terms of the psycho-social consequences of the occurrences of the disease or, as a multifactorial relationship between physical, psychological and social causes at the onset and during the development of the disease.

The last aspect seems a peak point with which, even in the absence of a specific theory, it is possible to near an approach that can be clinically shared. It is in fact evident that choices in life, habits and patterns of emotional reactions condition the susceptibility to diseases and their development and, simultaneously, derive from early experiences and mechanisms of defence and adjustment developed in the course of one's personal and transgenerational history.

On the level of the experience of the disease, the biological form and the type of treatment do not only influence the physical consequences, the relationships and the quality of life. They also activate emotions, thoughts and fantasies that could be inscribed in a context of meaning which derives from a personal and cultural background of conscious and unconscious beliefs and experiences. Manifestly the sense of the disease will therefore be that given by the medical explanation and by the choice of treatment. On a deeper level it will be that given by a system of interpretation and reconstruction which constitute a sort of parallel theory that greatly influences the patients' and their families' attitude to the disease. The carers' experiential and cultural background functions similarly. If the carers ignore their cultural and experiential background splitting it from their professional technical apparatus they will act out the countertransference in the therapeutic relationship. It is our belief therefore that it is not possible to call attention to the need for training and its specificity in the field of oncology without facing the presupposition of the need for a cultural integration of the biological and psychological aspects in the basic professional syllabus of doctors and psychologists. Without a basic training which enables one to understand the somatic expression of the disease and to deal with the emotional and social aspects as well as the relationships, psycho-oncology risks becoming a specialistic area without foundation.

The problem is how to structure the possibility of keeping inside the image of a complex whole without losing the specific tools of one's own role. In fact, it is not only necessary to take into consideration the bio-psycho-social aspects and to entrust them to several professional figures. Indeed, it is equally necessary, for all the professional figures dealing with the patient, to have the structure of a common heritage in their background. This will enable them to communicate, decode the language of body and mind, make out what the real needs are out of the confusion, help the patients gain awareness without perceiving them as competing with the

management of the treatment, and finally, create a programme that is congruent, more efficient and less costly in personal and social terms.

In psychotherapy attentive listening may be defined as a special attitude which presupposes empathy and symbolic capacity in order to allow the patient to re-experience and communicate, verbally or not, the deeper layers of his malaise, thus sharing and making space for them in the mind. This can be assumed also for patients with somatic diseases. In the inevitable stage of somato-psychological regression patients speak above all with their bodies. It is precisely this language that one must be able to listen to with one's own psyche-soma. In oncology the carer must be able to bear and hold the patient's deep regression connected to a mortal threat. He must be able to listen and identify with the real possibility of dying without losing himself (De Luca, Mazzei et al, 1992).

If the doctor, who has a physical experience of the body, must be able to access the meanings of body language, the psychologist, trained to understand the symbolical language of the mind, must be able to come into contact with, and open up to the concrete and bodily vicissitude of the patient. In fact, if the modality of the diagnosis and the treatment may induce the patient to experience the disease as in a body split from the mind, the psychological approach may induce the patient to experience it, via intellectualisation, on a psychological level split from the somatic level. This contradicts the objective of helping the patients to integrate the experience of the disease in order to reconstruct the continuity of existence and give them a feeling of development. It also supplies a dangerous mechanism of defence which, with the omnipotent fantasy of being able to control the diseased body with the mind, takes the patient away from the possibility of fully perceiving the physical need. From this point of view we consider it necessary for carers in the psychological area to have, first and foremost, extensive personal training in order to be able to work through very painful countertransference experiences without running the risk of intellectualising and idealising. Secondly they need to be aware of the biological form of the disease, of the procedures behind diagnosis and treatment, of the prognosis and the somatic consequences such as they are presented and represented in the caring environment. They also need to be aware of verbal and body language on which the patient-carer relationship is based. Observation and exchange with the medical area help to define the context within which intervention will take place (time, space, expectations, objectives) and, on an inner level, to distinguish between countertransference fantasies and the anxieties that the vagueness of the term tumour inevitably brings up.

It is however necessary to be ready to face the role crisis which occurs in the course of this type of training.

Medical procedure rotates around one fundamental task: doing, acting. The doctor's field of operation is concreteness. The psychological procedure hinges on listening and understanding: acting is counter-therapeutic. The psychologist acts as a catalyst for the psychological reactions of his patient. The psychologist's field of operation is within the area of meanings and symbolical working through. The cancer patient

introduces the dimension of urgency and death, obliging both types of carers to upset their own stereotypes.

The scientific ambiguity on the nature and treatment of tumours and the evidence of unexpected recoveries cause in the doctors an oscillation between the omnipotent challenge with the equivalence tumour=death and the anxiety of experiencing operational paralysis and the failure of that fundamental task of curing by acting.

The psychologists are faced with the need to confront the concreteness of the disease. The setting is contaminated by medical manipulations, by physical suffering, by the real possibility of loss and death (De Luca, Mastroianni et al, 1992). The meeting of the two fields, that of the body and that of the mind, must take into account not only the need to create a shared language, but also the particular nature of the object, a chronically urgent and threatened patient.

In the early stages of the meeting between the medical and psychological roles the assumptions of the respective vocational choices become radical and competitive. The doctor who is not trained in dealing with relationships and who identifies with the diseased body withdraws from the symbolical understanding of physical suffering if he does not experience the acceptance of the body on the part of the psychologists. The psychologist, not trained to listen to that body which he is forbidden to touch and manipulate, sides with emotions and meanings, locked in the magic circle of non interference as regards the doctor-patient couple. One could say that medical-psychological training should be articulated on the need for a contamination of the split parts, which are usually protected by the respective professional settings, in order to be able to work through the anxiety related to loss, uncertainty and operational paralysis. Those who wish to concern themselves with training in the psycho-somatic field and, in particular, in the psycho-oncological field need to face the constant work of working through the passage from defensive splitting to operational splitting.

Let us conclude with a thought from G. Vetrone (1986): a psychoanalytically trained observer, who comes into contact with an institution, is quite soon aware of the fact that inappropriate splitting operates within it, for he discovers with amazement, anxiety and disdain, that some human needs are denied and the patient is related to as if he were a part-object. Recognising the splitting is a sterile operation if one does not understand the specific anxiety which made such a defence necessary. The observer must be able to identify not only with the more evident suffering, that of the patient, but also with that of the carers, which is generally more difficult to recognise precisely because, through splitting it disappears or becomes projected elsewhere. Apart from this process there is only space for moralistic judgement.

References

Balint M. (1957): *Medico, paziente, malattia*. Feltrinelli Milano, 1977

Carbone P. (1995): Il gruppo Balint e la medicina contemporanea. *Prospettive psicoanalitiche nel lavoro istituzionale*. 13, 2, (173-182)

Funzione Gamma, scientific online magazine University "Sapienza" of Rome, registered with the Court Rome Civil (n. 426 of 28/10/2004)– www.funzionegamma.it

Chiozza L.A. (1978): *Psicoanalisi e cancro*, Borla ed. 1981, Roma

Comazzi A.M. (1995): Il gruppo Balint e la formazione psicologica del medico. *Prospettive psicoanalitiche nel lavoro istituzionale*, 13,2, (165-172)

De Benedetti Gaddini R. (1992): L'ascolto terapeutico in oncologia, in (G.Crocetti) *Ascolto terapeutico e comunicazione in oncologia*, Borla ed. Roma

De Luca A.M. (1997): La psicoterapia in ambito istituzionale: interventi in oncologia ematologia. In (C.Bressi, G. Invernizzi) *Interventi psicoterapici in oncologia*, (19-30), CIC Edizioni Internazionali, Roma

De Luca A.M. (1999): Atteggiamento dei curanti nella comunicazione con il paziente oncologico e consenso informato. Una indagine esplorativa. *Giornale Italiano di Psico-Oncologia*, 1, 2, 46-51

De Luca, Mazzei R. et al (1992): Gruppo Balint con operatori oncologi: resoconto di una esperienza. In (G. Crocetti) *Ascolto terapeutico e comunicazione in oncologia*, Borla ed. Roma

De Luca A. M., Mastroianni L. et al (1992): Problemi di integrazione in una équipe medico-psicologica. In (G. Crocetti) *Ascolto terapeutico e comunicazione in oncologia*. Borla ed. Roma

Fornari F. (1985): *Affetti e cancro*, Raffaello Cortina Editore

Vetrone G. (1986): Introduzione. *Prospettive psicoanalitiche nel lavoro istituzionale*. 1, (1-10)

Winnicott D.W. (1966): Psychosomatic illness in its positive and negative aspects *International Journal of Psycho-analysis*, 47 (510-516)

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